DISCHARGE PLANNING
ADVISOR

March/ April 2011: Vol. 4, No. 2
Pages 13-24

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Financial Disclosure:
Editor Rebecca McCarthy, and Executive Editor Russ Underwood report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor/ Nurse Planner Toni Cesta discloses that she is principal of Case Management Concepts LLC.

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Transition planning, management focus on continuity of care

Have we moved beyond the concept of "discharge"?

Don't say "discharge" to **Hussein Michael Tahan**. He prefers that you use the word "transition," as in transition planning and management.

Tahan is an independent consultant in hospital development, management and operations, and health care delivery system design. He also holds a doctorate in nursing science. He recently served as the executive director of International Health Services at the New York-Presbyterian Hospital and the University Hospital of Columbia and Cornell, in New York City.

In a hospital setting, discharge may imply an end, he says, while transition implies continuity. It suggests that care will be continuing, either with different healthcare professionals in a new setting or with the patient's family at home.

Whoever is taking over the job of providing care must understand the patient's needs, says Tahan, a member of the Case Management Society of America (CMSA) and a participant in the National Transitions of Care Coalition (NTOCC).

And the first need is for timely, comprehensible information.

In the past, Tahan says, health care professionals were focused primarily on discharges from a hospital setting. But he would like to see more attention paid to transition planning.

There are many types of transitions, he said. They can be from the emergency room to critical care, to a different floor in a hospital, or from one part of a healthcare organization to another — for example, from acute care in a hospital to skilled care in a rehabilitation facility or a nursing home. Or it may be a matter of just going home. Transitions may be made from general practitioner to specialist, or from acute care to hospice care, with the consequent shift from curing to end-of-life care.

Transition planning is important, Tahan says, in order to maintain quality of care, patient safety, and the efficient and effective delivery of care, and to assure a good, comfortable, rewarding experience for the patient.

To deal effectively with transitions, you have to be a superior communicator, Tahan says. In every setting and at every stage, there's a message that needs to be communicated.

There's someone who wants to share the message, and someone who needs to receive it. To do this well, an organization needs to develop a basic

communication model, a way to implement these messages within the system, so that transitions will produce the most positive outcomes possible.

Case managers may assume somebody is going to inform other healthcare providers about the patient when he or she goes from one setting to another. But such assumptions often result in a failure to pass on the necessary information in a timely fashion. Or the message given may not tell the total picture of what needs to be shared.

To set up the system properly for any given situation, one needs to step back and identify the owner of the communication, and the person responsible for making sure the communication is taking place, Tahan says. Then one needs to be sure the proper people know that a particular person is responsible for ensuring that the message is passed along.

More often than not, he says, the person responsible for passing on such messages is the case manager.

Tahan says the National Transitions of Care Coalition looked into the situation and identified relevant issues in the health care system that enabled members to come up with a model of communication that's simple and applicable in any setting. Anyone can take it and implement it. (It can be found online, along with other helpful information, at http: www.ntocc.org.)

Patients and their families have to consent to the plan of care, Tahan says, and become partners with the healthcare professionals. Is the patient going home to nothing? Or home to receive outpatient care? Or to another facility?

"It's important to communicate with all the team members," and to understand the transition plan and the associated financial and reimbursement implications, he says.

It's not enough to say, "'Well, we're going to get an MRI.' We're going to see what the results show and whether the patient meets the criteria for a skilled care facility," he said.

One person on the team assumes responsibility for communication. If the patient is moving to a skilled care facility, the team member in charge of communication contacts the skilled care facility and informs it of the plan of care.

"In the past, we may have faxed information, but not followed up to make sure the information went to the right office," Tahan says. "It sat there and nothing was done with it. Opening lines of communication is important, and it's got to be done in a timely fashion."

If the right information is shared, when the patient goes to the next healthcare provider, he, and/or his caregiver, knows whom to call when questions come up. If you first establish who is responsible on both ends, the continuity of care is maintained.

"In any transition, we tend to communicate

Discharge Planning Advisor (ISSN# 1940-8706) is published every other month by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, NE, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304.

POSTMASTER: Send address changes to Discharge Planning Advisor, P.O. Box 105109, Atlanta, GA 30348.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 7 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 7 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 7 clock hours.

This activity is valid 36 months from the date of publication.

The target audience for Discharge Planning Advisor is social workers, case managers, and nurses.

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Subscription rates: U.S.A., one year (6 issues), $199 Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

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medical procedures, but we have to communicate more than the medical plan; we have to communicate psychological, social and financial matters as well," Tahan says.

Does the patient have a DNR order? Have all medications been reconciled? Have all the issues been explained and documented? Where does the patient stand financially? Are they running out of benefits? Do they need transportation to dialysis treatment? Do they need equipment for home? Is there a social support system waiting for them?

"Whatever you do, you need to evaluate if it's working or not," Tahan says. "You need to come up with indicators of what you've done and measure its impact. You need to make sure that at every transition the provider has received the information, understood it, and can act on it." ■

Coalition takes aim at med reconciliation

Teams work to integrate caregivers

One of the most complicated issues facing medical staff, patients, and their caregivers is medication reconciliation. The medicines a patient is taking when he or she enters a hospital should be reconciled with any new medication the patient is given or prescribed while in the hospital.

But often, experts say, this doesn't happen. Things may start off badly and end worse. A patient who is rushed to a hospital in an ambulance after a heart attack may bring along no medicine. A family member trying to account for another's medications may remember the name of a prescribed drug, but not the dosage or how often it's taken. Or someone may have a dim memory of a medication the patient no longer takes.

The problem can be compounded when a patient leaves one setting — say, the intensive care unit of a hospital — and moves to a sub-acute setting, where he or she may be prescribed even more medications. According to the Institute for Healthcare Improvement, 50% of all medication errors and 20% of "adverse drug events" in a hospital are caused by insufficient communication during transitions of care.

"When you overlap medication reconciliation with multiple medical conditions, that's when the reconciliation really becomes a nightmare," says **Cheryl Phillips**, MD, past president of the American Geriatrics Society and Chief Medical Officer at On Lok, Inc., in San Francisco.

In the hospital, when a patient is preparing for discharge, she may receive a complete list of medications, but may not be able to read. Or the patient's memory may be less than reliable and he may not recall whether he should take the medicine in the morning or the afternoon. Or the list itself may contain errors.

Teams of healthcare professionals from several New York hospitals, rehabilitation centers, nursing homes, and hospice organizations are participating in the Transitions in Care-Quality Improvement Collaborative (TC-QuIC), a part of the United Hospital Fund in New York City (http://www.uhfnyc.org/initiatives/family-caregiving). Team members know that most often, the responsibility for administering a patient's medications falls to a family member or close friend.

Ten years ago, **Carol Levine**, who directs the Families and Health Care Project (TC-QuIC is an initiative), and other healthcare professionals, convened focus groups to talk about some of the problems involved in transitions of care.

They wanted to hear from family members, the people who would be responsible for patients once they got home, and to learn how they might make the process smoother and safer for the patient.

"The overriding message was, 'I wasn't prepared,'" says Levine. "Today, if we repeated those focus groups, they would say the same thing louder and more vehemently."

A family caregiver in charge of another's medications may have to compare the hospital's name for a drug with what it might be called in his or her local pharmacy. The medicine may have a different name and a different price, it may be a brand name instead of a generic, or it may be something an insurance company is not going to pay for.

The teams in the collaborative first contact family members in the hospital to determine who will be responsible for overseeing the patient's care. Early on, they identify the family caregiver, assess that person's needs, and integrate them into the care plan.

"What works is to have one person who is going to be there," says Levine. "And to tell them often what's expected."

Later, they contact the family caregiver about medications. If the patient is moving to a nursing home for rehab, they contact the caregiver again

about details relating to that transition and ask about medications.

"Going to the nursing home doesn't mean it's a long stay," Levine says. "We start planning with them for the day of discharge, finding out what preparations we need to make and what they need to have."

And they close the loop with the nursing home, making sure providers there have the necessary information about medications. When the patient goes home, a team member calls and checks in with both the caregiver and the patient, trying to learn if the medicine is causing any trouble.

"It's a continuous process to make sure everything is going right," Levine says. "The family member has to follow up as well, and to report if they see the patient acting strangely. Elderly people sometimes don't respond to medication the same way that younger people do."

Every family is different, with its own set of challenges, the TC-QuIC teams have found. The person designated as caregiver may have health problems of his or her own, or may not be willing to do what is required, such as administer an injection. Another family member may be willing to help, but be unable to do so because of a new baby, a physical disability, or a conflict at work.

"We talk with the caregiver and try to learn how we can get them the help that they need," Levine said. "We continue to check in with them to learn how we can help."

If a family member doesn't get the right instructions about medications and the patient has a reaction, he or she will be right back in an emergency room. So it's imperative that the caregiver understands how the medicine works and what he or she has to do.

The teams are keeping data about what works and what doesn't and are making changes as they go along, improving what they are doing as they are doing it. (There is information on how providers and family caregivers can work together at http://www.nextstepincare.org.) The collaborative teams found that the institutions that sent patients back and forth had never developed a systematic way to communicate. Now they have one and are making things better. Data are being collected from all members in the collaborative, which will end in June. Another will begin in the summer.

"In my own view, if any hospital can do a really top-notch job of medication reconciliation and medication training, they will see their readmissions go down," Levine said. "That's the real driver of these readmissions, and they are avoidable." ■

Take 'time out' for discharge, expert says

Make sure the essential pieces are in place

Health care professionals are familiar with the "time out" surgical teams take before beginning an operation. Teams check and validate vital information on each patent in order to prevent drastic mistakes.

Across the country, the operating room time out has become standard protocol, mandated by The Joint Commission for accredited health care facilities. The World Health Organization has created a safety checklist for surgical teams to follow. The challenge, of course, is to get every team member involved in the verification process, but time outs have been shown to drastically improve surgical outcomes.

Since a time out has proven effective in an operating room setting, wouldn't it make sense for case managers and others to try something similar with discharge planning? says **Toni Cesta**, PhD, RN.

Cesta thinks it does make sense — it's proving effective in her healthcare setting. She's the Senior Vice President for Operational Efficiency and Capacity Management at Lutheran Healthcare in Brooklyn.

"The concept is to make sure the most essential pieces of discharge planning are in place before the patient leaves," says Cesta. "Things are rushed, and some things get neglected. But before you let the patient leave, you go down a checklist."

Each hospital — or other health care setting, for that matter — could customize its checklist and devise questions about what's important to it.

These questions could include:

- Are all the necessary prescriptions filled?
- Is needed equipment going to be delivered to the patient's home?
- Is the next doctor's appointment already made?
- Has any outpatient testing been scheduled?
- What's the date of the first home care visit?
- Does the patient know where to go for physical, occupational, or speech therapy? How is he or she going to get to therapy?

Going through a list of critical care items "needs

to be done more than once, not just when the patient's leaving and there's drive-by discharge planning," Cesta said. "For this to be successful, you need to build redundancy and repetition into it, because patients and their care partners need to hear this more than once."

Years ago, people used to recover in a hospital. They would simply stay put until they were completely well. Now, economic and social changes have altered that scenario, with insurance companies not wanting to pay for an extended hospital stay. Patients recover in other settings, such as subacute centers and skilled nursing facilities, before going home.

"Everything is so accelerated," Cesta said. "The length of the hospital stay is shorter, the patients are sicker when they leave, discharge planning is more complicated. We have to say, 'Did we do everything we needed to do?" before we send them to another setting."

With a time out, the discharge process should be less hectic, she said, because people would know what to tell a patient. But one can't assume staff are actually going over a checklist with patients and their care partners multiple times. Lutheran Hospital in Brooklyn is starting to do chart audits to make sure the staff are doing a discharge time out. And the audits are becoming a part of the case managers' annual evaluation. ■

Readmissions are costly to providers, payers

Collaborate to ensure smooth transitions

In today's healthcare environment, as patients are being discharged from the hospital sicker and quicker than ever before, some patients are in and out of the hospital as if they are going through a revolving door, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company based in Huntington, NY.

"Something happens between the time people leave the hospital and when they are readmitted within a short period of time. As case managers, we need to identify what is happening and develop a concerted plan to avoid it," Mullahy says.

The problem is especially acute among Medicare recipients who often are frail with multiple comorbidities and polypharmacy issues. They might be socially isolated with little family support and have hearing and eyesight problems that impair their ability to understand and carry out their post-discharge plan, she adds.

According to a study in *The New England Journal of Medicine*, nearly 20% (19.6%) of all Medicare beneficiaries discharged from the hospital are readmitted within 30 days, and 35% are rehospitalized within 90 days.[1]

Data posted on the Centers for Medicare & Medicaid Services (CMS) Hospital Compare web site (http://www.hospitalcompare.hhs.gov) in July 2010 shows the 30-day readmission rates were 19.9% for heart attack patients, 24.7% for patients with heart failure, and 18.3% for patients hospitalized with pneumonia from July 1, 2006, to June 30, 2009. These rates were essentially the same as the 2005-2008 rates. The average stay of rehospitalized patients was .6 days longer than patients in the same diagnosis-related group who had not been hospitalized for at least six months, *The New England Journal of Medicine* study reports.

When she spoke at a seminar for case managers several years ago, Mullahy was startled to find that many hospital case managers were doing little to prevent readmissions because they believed that when patients were readmitted, that meant more revenue for the hospital. "We're supposed to be doing what is best for patients. As long as payers were reimbursing for it, nobody did anything differently to prevent readmissions," she says.

That's going to change since CMS has announced its intentions to penalize hospitals when patients with pneumonia, heart failure, or heart attack are readmitted within 30 days, beginning with discharges on Oct. 1, 2012. The agency has declared that it is likely to add other conditions to the list in the future. In addition, an explicit provision in the Patient Protection and Accountable Care Act mandates that in fiscal 2014, hospitals in the highest quartile for hospital-acquired conditions receive a 1% reduction in total Medicare reimbursement, and CMS has proposed using hospital readmissions as one of the processes of care measures used to determine hospital reimbursement in its value-based purchasing system.

Readmissions are expensive, says **Cory Sevin**, RN, MSN, NP, director with the Institute for Healthcare Improvement (IHI), an independent, not-for-profit organization in Cambridge, MA that works with providers to achieve safe and effec-

tive healthcare. "In a report to Congress in 2007, MedPac estimated that readmissions within 30 days account for $12 billion in Medicare spending each year,"[2] Sevin says. "In addition, when patients go in and out of the hospital and are very sick, it impacts their quality of life. In the hospital, they are at risk for infections, falls, and medical errors."

The best way to prevent hospital readmissions is to make sure the patients are better managed and receive the care they need after they leave the hospital, says **Donna Zazworsky,** RN, MS, CCM, FAAN, vice president of Community Health and Continuum Care for Carondelet Health Network in Tucson, AZ. *(For tips on how to prevent readmissions, see story on p. 19.)* "Many patients are readmitted to the hospital because they don't have what they need to stay stable once discharged back into the community. If patients don't have the basic things they need to take care of themselves, it can derail a discharge," Zazworsky says.

About half of patients discharged from the hospital don't understand what to do when they get home, Sevin says. Hospital stays are very short, and inpatient education activities often do not ensure that patients and their caregivers understand the key information needed for the patient to stay stable, she adds. "When the discharge instructions are complicated and the patient is ill and frail, it's even harder to make sure they understand. Many times family members, primary care physicians, and post-acute providers don't have the information they need to help the patient remain stable," Sevin says.

Patients and family members need to understand how to take their medication, any dietary restrictions, signs and symptoms that indicate they should seek medical care, and who to call. Sevin advises using the "teach-back" method, which involves having patients or caregivers repeat their discharge instructions to ensure that they understand them. Post-actute providers need complete and accurate information about what happened during the hospital stay, medication regimen, details of the patient's post-discharge treatment plan as ordered by the physician in the hospital, and any psycho-social issues or other issues that could impact the patient's post-acute stay.

Case managers should make sure patients understand their treatment plan and their medications, that they have support at home, that they have a follow-up visit with a physician, and that caregivers and providers at the next level of care have the information they need to ensure a smooth transition, Zazworsky says. Sevin says, "A huge part of reducing readmissions is designing the care process across the continuum of care. Hospital case managers need to work with home health agencies, nursing homes, primary care physicians and specialists, and their counterparts at health plans to ensure that care is coordinated and that everyone is giving the patient consistent information."

Patients are at highest risk for readmissions during the first week after discharge, Zazworsky points out. For that reason, it's critical to make sure that patients have a follow-up visit with a primary care physician or a specialist within a week of being discharged from the hospital. "Case managers can do a wonderful job of educating patients, but if they don't get that follow-up visit, they are likely to have problems after discharge that could result in a rehospitalization or emergency room visit," Zazworsky says. "The linkage to the community beyond the hospital walls is critical."

It's not enough for case managers to come up with a discharge plan. They have a responsibility to make sure that the care plan they set up is working, that the supplies the patient needs at home were delivered, that the home health nurse showed up, and that the patient made a follow-up visit to the doctor, Mullahy says.

Identify the cause of readmissions

Case managers need to identify the causes of readmissions before they can begin to make changes in the discharge and follow-up processes to keep patients from coming back, Mullahy says.

"Providers and payers need to look backward before they start to look forward and to analyze each readmission to find out the root causes. Then they can start to address the issues that contribute to readmissions," Mullahy says.

For example, if patients are being readmitted to the acute care hospital after a stay in a skilled nursing facility, it might be that the transition to post-acute care wasn't smooth and gaps in care occurred, or it might be that the nursing home is providing less than optimal care, she says. If patients aren't seeing their physicians in a timely manner, it might be that they didn't understand the need to make the appointment within a week of hospital discharge rather than accepting the next available physician appointment, which might have been a month away, Mullahy adds.

"Find out what caused each readmission, identify trends, and go back and start chipping away at barriers and reasons for readmissions," she says. For example, many patients are readmitted because they don't get their prescriptions filled. Find out if it's because they can't afford the medication, they don't have transportation to the pharmacy, or another reason, Mullahy says.

REFERENCES

1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med* 2009;360:1418-1428.
2. Medicare Payment Advisory Commission. Report to the Congress, Reporting Greater Efficiency in Medicare, June 2007. Washington, DC: 2007. Accessed at http://www.medpac.gov/chapters/Jun07_Ch05.pdf.

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6 ways to prevent hospital readmissions

How to get the information you need

To prevent hospital admissions, gather as much information as possible about the patient's discharge needs, psycho-social needs, and support systems in the community, **Cory Sevin**, RN, MSN, NP, director with the Institute for Healthcare Improvement advises. Talk to family members and primary care providers who know the patient and can provide first-hand information, Sevin says.

Here five more tips from the experts on how you can keep your patients from being readmitted to the hospital:

• Look for barriers, such as cost or lack of transportation, that could prevent patients from receiving post-acute treatment, and problem-solve before the patient leaves the hospital. Work with patients to make sure that they can pay for any outpatient services or medications that are not covered by insurance, and help them get assistance if they can't pay. If something isn't covered by their insurance, contact the doctor to see if the treatment plan can be changed, suggests **Donna Zazworsky**, RN, MS, CCM, FAAN, vice president of Community Health and Continuum Care for Carondelet Health Network in Tucson, AZ.

• Make sure that chronically ill patients have the equipment they need to monitor their conditions after discharge and know how to use it, Zazworsky suggests. For example, make sure patients with diabetes obtain a glucometer that is covered by his or her health plan, she adds. If possible, provide the glucometer before the patient leaves the hospital.

• Help patients with chronic illnesses enroll in a disease management program, Zazworsky recommends.

• Make sure patients and caregivers understand the patient's condition, medication regimen, red flag signs and symptoms, and who to call if they occur, Sevin suggests. Use the teach-back method to make sure patients and caregivers understand, rather than just lecturing them.

• Implement a good hand-off to the providers in the next level of care, whether it's a rehab facility, skilled nursing facility, home care nurse, or physician. Make sure they have all the information about the patient's reason for hospitalization, medications, test results, plan of care, and discharge plan along with the ability to use the teach-back method to educate patients. Instead of waiting weeks after discharge to send the information, create a system to transmit it in a timely way, Sevin recommends. ■

On-site nurses reduce readmissions, overall LOS

Program saves health plan millions

By placing on-site nurse case managers in hospitals and post-acute facilities, Presbyterian Health Plan of New Mexico has saved more than $1 million in just 10 months, according to **Paula Casey**, MSN, RN, ONC, CCM, clinical director for inpatient and recovery services at the Albuquerque-based health plan.

The savings come from reducing readmission rates and from an overall reduction of length of stay for patients on the health plan's list of the top 15 diagnoses that result in readmissions, Casey adds.

Case managers in the health plan's Nurse Care

Coordinator program have home offices and work on-site at hospitals, skilled nursing facilities, and a rehabilitation facility in the Albuquerque area. The health plan case managers determine that members' needs are being met and address any gaps in care. They follow up by telephone after the patients are discharged to review discharge plans and needs.

As of January 2010, the 30-day readmission rate for Medicare Advantage members was 13%, far below the national average of 19.6% as reported by *The New England Journal of Medicine*, and the overall 30-day readmission rate for patients with all types in insurance was 6.8%. "My perspective is that a readmission is a failure of the discharge plan. When we saw the data on Medicare readmissions within 30 days, we knew we needed to do something better. Our readmissions rates are fairly low, but we still had opportunities for improvement," Casey says.

The health plan analyzed readmission data from all product lines — Medicare Managed Care, Medicaid Managed Care, and commercial products — and determined that its readmission diagnoses compared closely to Medicare's diagnoses. Medicare has announced that hospitals will be penalized for readmissions of patients with heart failure, pneumonia, and heart attack within 30 days after discharge. The health plan found that in addition to the three diagnoses cited by Medicare, a significant number of readmissions were occurring among patients with pancreatitis, dehydration, and septicemia.

The health plan's inpatient care coordination team looked at their own data, conducted a literature search, and identified steps they could take to reduce readmission rates. The team narrowed down the top 15 diagnoses that resulted in readmissions and identified patients with those diagnoses who were hospitalized. When patients with any of those diagnoses are hospitalized, a nurse case manager visits them in the hospital shortly after admission and again just before discharge whenever possible. With patients who have a very short length of stay, the case manager might make just one visit before discharge. When patients are from outside the Albuquerque metro area, the interventions take place by telephone.

During the first visit, the case manager talks about the role about the health plan in the discharge process and makes sure the patient understands his or her insurance benefits. On the pre-discharge visit, the case manager reviews the discharge plan with the hospital discharge planner and intervenes, if necessary, to make sure the discharge plan is appropriate. "We encounter situations where the patient is being transferred to a rehab facility, but there is no way that he or she can tolerate the required three hours of therapy a day, and instances where the patient is scheduled to go home the next day but hasn't yet walked to the bathroom," Casey says.

If a patient is being transferred to a post-acute provider, the health plan makes sure that the facility receives the discharge information and the orders for the patient. The case managers attend the care conferences at the skilled nursing facilities and observe the patients while they are in rehabilitation to make note of their progress.

During the post-discharge telephone calls, the case managers go over the discharge plan again and make sure that all of the supplies and post-acute visits and services have been set up. They ask patients to bring all of their medicine bottles to the telephone. The case managers go over what medications are in the home and what has been prescribed to make sure there are no duplications. They make sure that patients understand their medication regimen. They intervene if there are any gaps in care. For example, one patient failed to get her prescription filled after discharge, which put her at risk for severe complications. The patient told the case manager that she had no transportation to the drug store. The case manager got the prescription faxed to a drug store that delivered.

Most of the time, patients receive their post-discharge phone calls from the nurse care coordinators they see in the facility. The exception is if patients are enrolled or are candidates for a disease management program. In that case, the disease management health coach team makes the calls.

"When a patient gets out of the hospital or a post-acute facility, it's a wonderful opportunity to capture them at a time that they are aware of their chronic condition and motivated to change," Casey says. ■

Following up care cuts readmissions

Post-discharge phone calls are a key

WellPoint's initiatives to reduce hospital readmissions by following up with Medicare Advantage members after discharge has decreased

the readmission rate and reduced skilled nursing days, according to **Karen Amstutz**, MD, vice president and medical director of care management for seniors and state sponsored business for the Indianapolis-headquartered health benefits company.

"One of our key initiatives at WellPoint and across our health plans is to look at the cost of care and identify the areas where we can make the greatest impact," Amstutz says. "Our readmission prevention initiatives use a range of tactics to identify members at risk for readmissions at the time of discharge and provide the appropriate level of case management that will keep them out of the hospital."

WellPoint's post-discharge follow-up program is based on Eric Coleman's Care Transitions Intervention model. The model was developed by a University of Colorado team led by Eric A. Coleman, MD, MPH, a geriatrician and professor of medicine at the university. It has four main components, called "Four Pillars":

- teaching patients medication self-management;
- educating them to recognize warning signs and symptoms and what to do when they occur;
- ensuring follow-up care with a primary care physician;
- facilitating patients' ownership of their personal health records.

After Medicare Advantage members are discharged from the hospital, the health plan's outreach staff and case managers implement interventions that are based on the member's level of risk for readmission. Members at low risk receive telephone calls.

Based on the severity of their condition and their level of risk, other members would receive short-term telephonic case management or are enrolled in long-term complex case management.

The health plan's outreach staff call all of the Medicare Advantage population after discharge, regardless of their risk level, and are able to reach about 95% of them. These non-clinical staff members have been trained to conduct the post-discharge telephone calls and use a script developed by the health plan's multidisciplinary care coordination team.

About 10% of the low-risk members who receive calls have issues that need attention, Amstutz says. Common problems include confusion about medication or the treatment plan, untreated pain, or lack of caregiving support. In some cases, the home care nurse hasn't shown up or needed equipment hasn't been delivered. If a member is having problems or has a question, the staff can transfer the call directly to a nurse case manager.

The outreach staff members ensure that the members have a follow-up appointment with their physicians. If necessary, they can institute three-way calls with the physician office or transfer the member to a case manager to help coordinate the appointment.

Teams are assigned geographically

WellPoint's multidisciplinary Geographic Care Support Teams are a key to the success of the program, Amstutz says. The team includes medical directors, case managers, and utilization review nurses who are assigned by geographical areas, which allows them to focus on the resources and providers in their particular area.

The cross-functional teams conduct rounds on hospitalized members who have complex treatment needs and who have been in the hospital 10 days or longer without moving to the next level of care. While the patients are in the hospital, the team members discuss who is likely to be at risk for readmissions. They determine what the patients need after discharge to avoid hospitalizations and/or emergency department visits.

The health plan's utilization review nurses and case managers have separate functions, but they work as a team to coordinate care. This coordination has been the key to the program's success, Amstutz says. "We have found that it's more efficient to assign utilization review and case management responsibilities to different staffs. If one nurse is responsible for both functions, they spend a lot of time setting priorities and don't get as much work done," she adds.

Members who receive short-term case management often need help transitioning to the community. For example, a newly diagnosed diabetic might need education about managing his or her disease before being handed off to the health plan's disease management program. Members who receive long-term case management have complex needs and need interventions over a longer span of time.

WellPoint has implemented a pilot project in Georgia in which home health nurses meet face-to-face with recently discharged patients, reinforce the discharge plan, conduct medication reconciliation, and educate patients about symp-

toms that indicate they should call their doctor. "When someone visits members in their home, they can identify issues that might not be evident to a telephonic case manager. The pilot provides visits to a very low volume of members. Based on its success, we're working to develop ways to expand the program," she says. ■

Bridging the gap between ED and PCP

Reform puts problem area on front burner

There are literally dozens of studies that enumerate some of the problems that plague patients as a result of imperfect transitions of care. According to the National Institute for Health Care Reform (NIHCR), there will be an additional 32 million insured people by 2019, many of whom will seek care in hospital emergency departments (EDs). That makes improving care coordination between primary care physicians (PCPs) and the emergency department more important than ever. In a study of how well and how willing physicians are to communicate with each other, the NIHCR and Center for Studying Health System Change (HSC) found that there are few easy answers to the problems.[1]

Using phone interviews of 21 pairs of ED and primary care physicians, researchers discovered that real-time communication is best in some circumstances, but could be very time-consuming; that faxes could be of limited use and physicians questioned how carefully they were reviewed; and that shared electronic records could address some problems.

One problem that physicians and their champions often raise is that doctors do not get reimbursed for communicating with another doctor about a patient. While one might expect the good of the patient to trump issues of reimbursement, physicians are people and they will do more readily that which is rewarded. **Ann S. O'Malley**, MD, MPH, a senior researcher at HSC, has looked at physician perceptions about how well they and others communicate with each other.

In her most recent study[2], O'Malley found that physicians think they communicate more often and better than they really do. Tracking some 4,700 physicians, O'Malley and her colleagues asked about perceptions of communications about referrals and consultations. While 69.3% of primary care physicians reported sending notification of patient history at least most of the time, only a bit over a third of the specialists said they always or most of the time received such notification. And while more than 80% of specialists said they always or most of the time send results to primary care physicians, just 62.2% of those PCPs said that was so. The quality of the communications was also lacking, according to the study, which appeared in the Jan. 10, 2011, issue of the *Archives of Internal Medicine*.

Regardless of the perceptions, O'Malley also mentions the lack of aligned incentives for getting physicians to do better at ensuring patients who are seen in a hospital or by a specialist have their cases relayed efficiently and effectively to their primary care doctors, and likewise that those specialists have all the information they need about a patient when they need it.

"I was not expecting quite the gross differences we found, although we know coordination of care and communication between physicians is lacking in this country," she says.

There are a variety of reasons for the disconnect between perception and reality, along with the lack of incentives to provide great communication. Some of them might include process problems such as physicians thinking something was faxed and it not getting done, or not getting done in a timely manner. Some are physician problems, such as the legibility of notes that are faxed to other physicians. As for the problems with ED physicians in particular, O'Malley says her sample was not large enough to drill down to particular specialists. However, she notes that the sheer busyness of EDs and the increased complexity and severity of illness in the patients they see reduces the time they can spend on things like sending notes and phoning other physicians.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the May/June issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter.

But EDs see some of the most vulnerable patients: the old, the very sick, those with multiple conditions, children, and those who have trouble navigating health systems, such as immigrants and the poor, O'Malley says. That makes ensuring good communication and coordination of care even more important.

How do we solve the problem? O'Malley says she hopes reform will change the incentives so that there is some sort of reimbursement available for communication activities. There should also be ways to make such communications automatic and easy.

That is just what Medical City Dallas Hospital is working on, says **Bev Cunningham**, MS, RN, vice president clinical performance improvement at the HCA facility. While electronic medical records make knowing what has happened to patients easy for physicians who are part of the system, those who are not have more of a problem, she says.

Currently, the hospital is working on a process improvement project that will have primary care physicians phoning whenever they know a patient of theirs is coming to the ED, and the ED calling when that patient arrives. For unassigned patients, Cunningham says hospitalists handle communications. They are also considering a paper note that will be passed on between physicians at shift change.

Journal can smooth transitions

Another option is to create a paper or online journal that helps create smooth transitions, whether to another unit or the back to the medical home. In a study published in the *Journal of the Royal Society of Medicine*[3] in February, **Gurdev Singh** and his colleagues tested a journal developed by physicians and nurses using the Situation, Background, Assessment, and Recommendation (SBAR) format.

What they developed was used as a checklist for transitions, as an audit tool, and as a teaching tool. Initially only on paper, it quickly morphed to a Web-based tool, which may also address "Meaningful Use," says Singh.

Singh says that the lack of care coordination costs hundreds of billions of dollars per year and causes "a huge amount of harm" to patients and their families. Having timely and reliable communication between settings is the prevailing root cause, he says. The Joint Commission has recognized the importance, requiring "structured methods of transitioning patients." He thinks his study may be one way to address this need.

Rather than using a top-down approach, however, he thinks using a tool that was developed by the very people who will use it will result in better buy-in.

While noting that vulnerable populations are at particular risk from bad transitions, Singh thinks that "all groups are deficient" in this area. He hopes tools like his will help alleviate that problem.

REFERENCES

1. Carrier, E, Yee T, Holzwart RA. Coordination Between Emergency and Primary Care Physicians. http://www.nihcr.org/ED-Coordination.html.
2. O'Malley AS, Reschovsky JD. Referral and consultation communication between primary care and specialist physicians: finding common ground. *Arch Intern Med*. 2011 Jan 10;171(1):65-7.
3. Singh R, Roberts AC, Singh A et al. Improving transitions in inpatient and outpatient care using a paper or web-based journal. *JRSM Short Rep*. 2011 Feb 3;2(2):6. Available free online: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3046565/

SOURCES

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CNE objectives

Upon completion of this educational activity, participants should be able to:

- Identify particular clinical issues affecting discharge planning.
- Apply discharge planning regulations to the process of discharge planning.
- Describe how the discharge planning process affects patients and all providers along the continuum of care.
- Cite practical solutions associated with the discharge planning process based on independent recommendations from clinicians working in the field or from specific regulatory bodies.

CNE questions

5. According to Hussein Tahan, the term "transition" is preferable to "discharge" because it suggests that care will be continuing, either with different healthcare professionals in a new setting or with the patient's family at home.

A. True
B. False

6. How much does MedPac estimate hospital readmissions cost Medicare each year?

A. $10 billion
B. $12 billion
C. $14 billion
D. $15 billion

7. What was the readmission rate among Medicare Advantage members of Presbyterian Health Plan as of January 2010?

A. 19%
B. 16%
C. 13%
D. 6%

8. Approximately what percentage of low-risk members of WellPoint's Medicare Advantage Plan have post-discharge issues when they are contacted by the health plan?

A. 10%
B. 12%
C. 14%
D. 20%

Answers: 5. A; 6. B; 7. C; 8. A

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